Sunshine
State Adoption and Home Study Services

MEDICAL FORM

____
Applicant's full name

____
Date of Exam

Applicant's Height: _____________

Applicant's Weight: _____________

__________________________________is currently in good health, is free of all communicable diseases, and is mentally and physically capable of raising an adopted child. The applicant has a normal life expectancy and does not have a chemical or alcohol dependency.

____________________________ ______________________
Physician's signature Date signed

____________________________ ______________________
Physician's printed name License number

____
Physician's full address and telephone number

STATE OF: FLORIDA
COUNTY OF: __________________

Sworn and subscribed before me this ______ day of ___________________ in the year of 20____________ by ____________________________ who is personally known to me ______

OR who produced a driver's license for identification _______

ID#____

Notary Signature: ____________________________________

My Commission Expires: _____________________